GAMP COMMUNITY CLINIC REFERRAL AUTHORIZATION

Primary Clinic

Today's Date:_____
Clinic's Phone No:_____
Clinic's FAX:_____

A. GAMP Eligibility (To be completed by Clinic)

Patient Last Name:	Patient First Name:
D.O.B.	**GAMP effective Date:** From: To:
SS#:	

B. Referring Physician's Statement

Referring Physician:

Reason for referral/Procedure:

Specialty/Services being requested: ☐cardiology ☐dermatology ☐endocrine ☐ ENT ☐ GI ☐ GYN ☐ GYN/oncology ☐hand ☐hematology ☐hem/oncology ☐hepatology ☐infectious disease ☐nephrology ☐neurology ☐oncology ☐ophthalmology ☐orthopedics ☐pain mgmt ☐physical therapy ☐podiatry ☐ PM & R ☐pulmonary ☐radiation oncology ☐rheumatology ☐spine care ☐sports med/ortho ☐surgery, general ☐surgery, vascular ☐surgery, neuro ☐ TES ☐urology ☐wound other:_____

Send Pertinent Clinical Data Required, i.e. Progress Notes/Diagnostic Reports

C. Consultant's Disposition

This patient was seen in (Clinic)	On (dates)	Phone:
Patient seen by (Physician Name)		FAX#:
Preliminary Diagnosis:		
Provider of services:		Provider Tax ID#
Address where services will be provided**:**		
Service(s) being requested:		

D. Authorization (*GAMP use only*)

Specialty Clinic Consultation: This patient is authorized for a maximum of _____visits in (Clinic) Auth. #:

Outpatient Procedure:
at Auth #: **P**

Elective Inpatient Admission: No preauthorization needed

Outpatient Therapy:
at Auth#: **T**

- □ **Send Medical/Progress Notes**
- □ **Referred to GAMP Medical Consultant**
- □ **Request Denied**
- □ **Request is not a covered benefit**
- □ **Return to PCP for Continued care**
- □ **Request is not a covered benefit**
- □ **No GAMP authorization needed for this request**
- □ **Notes are illegible (please refax)**
- □ **Notes do not support this request**
- □ **Conservative medical intervention must be tried first**

Issuance of number indicates medical necessity, and does not necessarily guarantee payment of services.

FAX form to (414) 289-8516 Utilization Management : Telephone # 289-6731

form updated 2/2008